



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

South Texas Radiology

Respondent Name

Praetorian Insurance Co

MFDR Tracking Number

M4-17-2954-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We originally sent our bills to Berkshire Hathaway Insurance on 10/12/2016. We received correspondence from Berkshire Hathaway informing us they are no longer the Carrier for the employer. We then went on to research for the correct WC Carrier. We called the employer & we provided with Sedgwick claim & fax information. Now our claims & requests for reconsideration are being denied. Please assist us in obtaining final adjudication."

Amount in Dispute: \$40.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the dispute charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2016	73562 -26	\$14.88	\$40.75
October 7, 2016	73070 -26	\$12.65	
October 5, 2016	73590 -26	\$13.22	

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.

4. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
5. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
6. The insurance carrier reduced payment for the disputed services with the following adjustment codes:
 - 29 – The time limit for filing has expired
 - 937 – Service (s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. What is the applicable rule that applies to the fee guideline?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking \$40.75 for professional medical services rendered on October 5th and 7th, 2016.

The insurance carrier denied the disputed services with adjustment reason codes: 29 – “The time limit for filing has expired” and 937 – Service (s) are denied based on HB7 Provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.”

28 Texas Administrative Code §133.20(b) states in pertinent part,

Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

Texas Labor Code §408.0272(b) provides that:

Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

- (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
 - (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
 - (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
 - (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
- (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Documentation was found to support that an exceptions described in Texas Labor Code §408.0272 applies to the services in this dispute. Specifically, a document dated December 23, 2016 from Berkshire Hathaway that indicates bill were being returned as “The employer’s policy coverage expired on 6/01/15 prior to the date of injury on 10/7/16” and a faxed confirmation of bill submission of eight pages to Sedgwick dated December 30, 2016.

For that reason, the bill in dispute will be reviewed per the applicable rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (c) states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

Date of Service	Submitted Code	Billed Amount	Allowable	Maximum Allowable Reimbursement (DWC Conversion Factor / Medicare Conversion Factor) x Allowable = MAR
October 5, 2016	73562 -26	\$41.00	\$33.39	$\$56.82/35.8043 \times 33.39 = \52.99
October 7, 2016	73070 -26	\$31.00	\$25.39	$\$56.82/35.8043 \times \$25.39 = \$40.29$
October 5, 2016	73590 -26	\$30.00	\$26.74	$\$56.82/35.8043 \times \$26.74 = \$42.43$
			Total	\$135.71

3. The Division finds the requestor has supported that within 95 days of notification of the correct carrier they submitted a medical bill to this carrier (Sedgwick). The maximum allowed reimbursement per Rule 134.203 (c) is \$135.71. The requestor is seeking \$40.75. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$40.75

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$40.75, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	July 7, 2017 _____ Date
--------------------	---	-------------------------------

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.